

REPORT OF THE INVESTIGATION
OF THE DEATH OF MR. RUSSELL SMITH,
RESIDENT OF WINNSERV HOME,
146 WORDSWORTH WAY, WINNIPEG.

MANITOBA COMMUNITY SERVICES

February 8, 1988

TABLE OF CONTENTS

INTRODUCTION	1
CIRCUMSTANCES OF DEATH	1
BACKGROUND	2
ISSUES AND RESPONSES	3
1. MONITORING OF BATHING	3
2. PARENTAL INVOLVEMENT	6
3. MEDICATION REDUCTION PROCEDURES	9
4. MEDICATION DOCUMENTATION	10
5. RESIDENT FILE SUMMARY SHEET	12
6. FIRST AID TRAINING	14
7. EMERGENCY NOTIFICATION PROCEDURES	15
8. STAFF TURNOVER	16
ANALYSIS OF ADDITIONAL PARENTAL CONCERNS	18
GLOSSARY OF TERMS	23

INTRODUCTION

Following the December 19, 1987 death of Mr. Russell Smith, the Honourable Maureen Hemphill, Minister, Manitoba Community Services, on December 22, 1987 ordered a review of the policies and procedures of the Winnserv home.

The following report provides the background to the issues and also outlines the actions that will be taken to prevent similar tragedies.

The report is based on interviews with Mr. & Mrs. D. Smith, parents of Russell Smith; Winnserv staff and Community Service workers.

CIRCUMSTANCES OF DEATH

On December 19, 1987 Russell Smith was bathing in the lower bathroom of the Winnserv residence at 146 Wordsworth Way. A co-manager and a support staff worker were on duty. In addition a male hygienist had arrived while Russell Smith was bathing. The residential co-manager, upon checking Russell Smith approximately five to seven minutes after he commenced bathing, discovered him with his face under the water in the bathtub. Emergency personnel were summoned by the support staff worker. The co-manager and a male hygienist commenced resuscitation. Defibrillation was administered by emergency personnel upon their arrival. Russell Smith was transported to Grace Hospital where he was pronounced dead.

BACKGROUND

Russell Smith had been placed at the Manitoba Developmental Centre in October 1971. He remained there until March 1987, when he was placed in the Winnserv residence at 146 Wordsworth Way. From 1971 to 1987 he had been discharged to his parental home on three occasions, and after each, he was returned to MDC because of behavior problems.

Russell Smith was the subject of an Individual Planning Process Report and meeting on April 2, 1986. Mr. & Mrs. Smith, parents, attended as did MDC staff and a community services worker and a volunteer. Russell Smith's background was reviewed and this included health, behavior, daily routine, medication, and his self-help skills and needs.

He was described as being mentally retarded and an epileptic. He suffered seizure disorders and these were described as Grand Mals (unconsciousness but no spasms), Petit Mals (quickly recovers on his own) and Drop seizures. He also suffered a visual handicap - not having vision in his left eye and only 70% in his right eye. It was noted that he would fake a seizure. He was psychologically assessed as performing within the mild range of retardation. It was noted that a staff member is always present in the bathroom, and that, although he required minimal assistance with washing, he does need help with the water temperature; getting in and out of the tub and shampooing. At home his Mother helps him with grooming and shaving; she doesn't ask him if he wants a bath, just says it is ready and he goes willingly. His needs were outlined and included expand personal hygiene skills and teach Russell how to adjust water properly.

On January 22, 1987 an evaluation clinic was held and it was decided to place Russell Smith in the community. On March 4, 1987 Russell Smith was placed in the Winnserv Home at 146 Wordsworth Way, Winnipeg, Manitoba. The residence at 146 Wordsworth Way is licensed to provide care up to Level V residents. During the period from March 4 to May 26, 1987, Russell Smith was involved with in-house day programs provided by Winnserv. This enabled him to adapt to his new surroundings and community.

ISSUES AND RESPONSES

1. Finding: There was inadequate monitoring of bathing where the resident was at risk.

Actions: Residential care operators will change procedures for monitoring independent bathing where the resident is at risk. Where appropriate, they will use less intrusive measures, including voice monitors. Manitoba Community Services will establish standards and communicate this requirement to all community residence operators.

Background: A review of the Seizure Activity Record provided by Winnserv indicates that provision is made to record the time, date, symptoms and length and location of seizures. The entry of May 20, 1987 reveals that Russell Smith experienced a Drop Seizure at 6:20 p.m. when he, "dropped into water while bathing in tub". The entry of June 20, 1987 indicates that at 3:48 p.m. he experienced a Drop Seizure and, "fell face first into the tub water during bathing". An Incident Report dated May 13, 1987 indicated that Russell Smith experienced two seizures between 4:15 -

4:30 p.m. while at the doctor's office. The entry dated May 13 in the Seizure Activity Record indicates that a seizure took place at 12:05 a.m. while Russell Smith was getting into bed. The two seizures at the doctors office were not recorded in the Seizure Activity Record. The incident Report dated September 15, 1987 indicates that he experienced a seizure and this was not recorded in the Seizure Activity Register.

Russell Smith's seizure activity was noted in the MDC - Discharge Summary dated March 20, 1987 and notes that, "his seizures occur about once a month, sometimes 8 to 10 in a month". "Occasional tonic clonic type lasting about 30 to 40 seconds." His seizures were also described in the Individual Planning Process report dated April 2, 1987.

As previously noted in the Individual Planning Process Meeting and Report of April 2, 1986, a staff member was always present in the bathroom with Russell Smith, although he required minimal assistance with washing, controlling water temperature, shampooing and getting in and out of the tub.

Mrs. Smith wrote to the staff at 146 wordsworth Way on February 8, 1987. In her letter Mrs. Smith provided information that she obviously felt would be useful to the staff. It is noted that this letter was written prior to Russell Smith's placement at 146 Wordsworth Way. Mrs. Smith provided the name of a doctor; that her son's health is good; and that he will claim a bad cold when he has none. She states that from 1:00 to 4:00 p.m. is a prime time for seizures and that he may have a series while eating lunch. She suggests a mixture of $\frac{1}{2}$ coffee and $\frac{1}{2}$ milk to prevent his

getting scalded. She describes his Drop Seizures; reaction to sudden noises; falling down; body spasms and that he should not be moved until he is relaxed. Mrs. Smith states that her son should not be around the stove or hot water and at home he is forbidden to touch the coffee pot, as he was scalded some years ago. She further states that for the same reasons he should not be, "left in the bathroom alone, as the warm water sometimes results in a G.M. Seizure, not convulsing - but unconscious and is quite confused when he recovers and disoriented as well". The letter further explains Russell Smith's limited vision and his main interests. She cautions that her son has memorized a number of telephone numbers and he will call if not monitored.

A Bathing Assessment Sheet of Russell Smith, covering the period from June 24 to July 18 had been completed by Winnserv staff. At the staff meetings of May 4 and 11, concerns were raised about the male bathing program. The minutes of the meeting of July 2, 1987 are significant in that staff expressed concern that Russell Smith resented staff being in the bathroom while he bathes. It was noted that because he scores high (80 percentile) in hygiene (Bathing Assessment), he will be allowed the dignity to bath independently. It is further noted that, "staff must check every few minutes to ensure that he is okay". A Program Review, dated July 7, 1987, noted that he is doing very well, is left alone for about 5-10 minutes and doesn't want to get out of the tub. Winnserv staff advised that when they checked on Russell Smith while he was taking his bath the staff would be told to "get away", "leave me alone" and similar remarks.

Mr. & Mrs. Smith expressed concern that not all staff were aware of Russell Smith's need for supervision during bathing. Mrs. Smith recalled that on one occasion she phoned for her son and was told by the residential co-manager that her son was in the bathtub. She informed that her son had to be supervised while in the tub. The Smiths were also concerned with not being made aware that their son had been allowed to bath independently and also that he had been bathing in the morning. They also raised the question of who sanctioned their son's bathing independently.

The residential co-manager claimed that she did not recall Mrs. Smith telephoning for her son and being told that he was in the bathtub. The Winnserv Program Coordinator of 146 Wordsworth Way was responsible for sanctioning the decision to allow Russell Smith to bathe independently. Winnserv staff advised that parents were not normally involved in program changes. Russell Smith was allowed to choose his own time for bathing to lessen behavioral problems and he chose to bathe in the morning.

2. Finding: There was inadequate parental involvement in the development of Mr. Smith's program.

Actions: Residential care operators will take additional steps to encourage parental/family participation. They should not make major changes in the resident's program without discussing these changes with the parent and/or Community Services regional staff. Care operators should ensure appropriate medical consultation when the resident is at risk; inform family of all program reviews and significant

events, such as doctor's appointments; and encourage parents to become involved in volunteer activities. Where parents do not attend a review meeting, they will be sent a copy of the program review. Manitoba Community Services will notify all community residence operators and regional departmental staff of these requirements.

Background: Mr. Smith stated that meetings with parents and Winnserv did not take place. Mr. Smith claimed that he held the same view of Winnserv that he held for years when very few meetings were held between parents and MDC staff. He questioned the reasoning that parents were never asked to volunteer their services, explaining that he felt this was one of the advantages of Russell Smith moving to Winnipeg. He felt that Winnserv did not want parents at the home. It was confirmed, through Winnserv, that the parents were not asked to volunteer their services.

Individual Program Plan Meetings were held on May 13, July 29 and November 19, 1987.

- a. May 13 Meeting: This meeting was attended by Winnserv staff and a Community Services worker. It was noted that, under skills assessment, a particular need for hygiene and shaving skills was emphasized. It was also noted that Russell Smith's medication had decreased.
- b. July 29 Meeting: This meeting was attended by Russell Smith, his mother, a community services worker, a member of the Winnserv staff and a representative from an outside day program. This meeting was a further assessment of Russell Smith's skills and limitations.

- c. November 19, 1987: At this meeting it was noted that a blood level test was not done by the doctor; some medication was discontinued and the doctor hoped to take Russell Smith off a particular medication within three months. It was also noted that there was a decrease in apparent seizures and that Russell Smith's aggressive behavior was decreasing. It was noted that a need for shaving skills was emphasized. Hygiene was not mentioned as it was at the May 13 meeting. Winnserv staff and a community services worker attended this meeting.

Mr. & Mrs. Smith also stated that their major frustration with Winnserv was with the lack of communication. Mrs. Smith recalled that she was never notified when her son had a doctor's appointment. Winnserv staff advised that Mrs. Smith made her wishes known to accompany her son on his first visit to the neurologist. Arrangements had been made, however Mrs. Smith could not attend. She did send a letter which was delivered by the staff. Winnserv staff did not believe that Mrs. Smith had again expressed a wish to accompany her son to the doctor. She would have been welcome to go along.

A Bathing Assessment Sheet, concerning Russell Smith, covering the period from June 24 to July 18, had been completed by Winnserv staff. At the staff meetings of May 4 and 11, concerns were raised about the male bathing program. The minutes of the meeting of July 2, 1987 are significant in that staff expressed concern that Russell Smith resented staff being in the bathroom while he bathed. It was noted that because he scored high (80 percentile) in hygiene (Bathing Assessment), he would be allowed the dignity to bath

independently. It was further noted that, "staff must check every few minutes to ensure that he is okay". Neither Mr. or Mrs. Smith attended the staff meeting of July 2, 1987 when the decision was made to allow Russell Smith to bathe independently.

3. Finding: Mr. Smith's medication was reduced because of parental concerns, and under medical supervision. However, no additional transitional safeguards were implemented.

Actions: Residential care operators will review all medication reductions and review safeguards with Community Services regional staff, parents, and the residents' physicians to ensure appropriate medical safeguards are in place.

Background: Mr. and Mrs. Smith were concerned about the number and dosages of medication being used to control Russell Smith's seizure activity.

At the M.D.C. discharge planning meeting, Mrs. Smith requested that Russell be referred to a different neurologist. The referral was made and the level of medication was gradually reduced, with Russell Smith seeing the neurologist monthly. There was also a decrease in the frequency of seizures, from a high of 7 in May and 5 in June, to 2 in October and November. In addition, inappropriate behaviours decreased.

4. Finding: While this finding was not connected with Mr. Smith's death, his change in medication was not properly documented on his medication chart. This was not noted in the review conducted by the Office of Residential Care.

Actions: Residential care operators will ensure that changes in medication are documented immediately. Manitoba Community Services is examining the licensing review procedures of its Office of Residential Care.

Background: A comparison was made between the prescription changes in Russell Smith's medication as noted by Winnserv in a medication review document and the medication document completed by the Winnserv staff at the time of actually administering the medication. The comparison reveals the following:

- a) March 1987 - Medication recorded as on discharge from MDC.
- b) April 1987 - No change.
- c) May 1987 - Doctor reduced the phenytoin dosage and this change is not reflected.
- d) June 1987 - Neurologist reduced phenobarital dosage to 100 mg. Change reflected.

- e) July 1987 - Neurologist reduced phenobarital dosage to 60 mg. Change not reflected.
- f) August 1987 - Phenobarbital dosage is recorded as 100 mg. This is incorrect. The dosage was 60 mg. and was reduced again to 30 mg by neurologist. This latter change is not recorded.
- g) Sept. 1987 - The phenobarital dosage is recorded at 100 mg. This should read 30 mg.
- h) Oct. 1987 - The phenobarital dosage was originally shown as 100 mg and this has been amended by pen. Unfortunately the figure can not be clearly read. The prescription was reduced for the Carbamazepine and this change is not clearly reflected.
- i) Nov. 1987 - No change.
- j) Dec. 1987 - No change.

The nurse advised that the errors were due in part to copying one month's data to the following month's sheet and partly due to not recording the changes. She assured that, notwithstanding the information above, the correct dosage would have always been administered because the drugs were supplied in the bubble packs. It would seem that there is room for possible error as the prescription changes did not necessarily coincide with the new supply of bubble packs. On July 14, the July Medication Document also reflects that there was some confusion and Russell Smith was not given his 4:00 p.m. medication.

5. Finding: The resident file summary sheet did not record some significant information, including safety concerns and Mr. Smith's seizure condition. Winnserv had been directed by the Department to use this standardized format.

Actions: Manitoba Community Services has reviewed standardized file formats and information requirements for community residence operators, and is modifying them to include safety and parental concerns.

Residential care operators will ensure their staff are familiar with the contents of each resident's file.

Background: Mr. & Mrs. Smith were concerned about a number of safety-related issues regarding the operation of the Winnserv residence:

- a. Residents may have had the use of the stove and appliances such as a blender;
- b. That a record should be maintained on each resident outlining areas where caution is required, such as, not being allowed alone in the street, epilepsy and seizures, and to be in possession of an I.D. bracelet;
- c. Fire safety; and
- d. Mrs. Smith, in particular pointed out that the stairs in the split-level home were a hazard to her son. When asked, Mrs. Smith stated that she did not visit the residence before her son moved in on March 4, 1987.

Winnserv staff advised that;

- a. There was a blender in the residence, however Russell Smith did not have access to it. He was not allowed the use of the electric stove. He performed very routine tasks in the kitchen such as ripping lettuce. Staff further advised that if Russell Smith used any of the laundry equipment, it was always under staff supervision. There is no suggestion that Russell Smith was injured while using a kitchen appliance.
- b. Review of the face sheet from Russell Smith's personal file revealed that mention was not made of his epilepsy and associated seizures. Russell Smith was in possession of an I.D. bracelet. There was no suggestion that Russell Smith was allowed into the street without supervision at any time, nor do the parents make this allegation. Mr. & Mrs. Smith were advising of the danger areas and they felt that this should have been recorded as a precautionary measure.
- c. Fire Safety reviews were carried out as part of the Residential Care Licensing Inspections and these were carried out in May and November 1987, with a very few minor recommendations being made.
- d. Regarding the potential hazard of the stairs in the residence described by Mrs. Smith, and that she informed that she had not visited the residence at 146 Wordsworth Way, prior to her son moving in, Winnserv staff recalled that, in fact, Mrs. Smith visited the residence when she personally delivered her letter dated February 8, 1987. At the time of

this visit, staff recalled that Mrs. Smith complained about the furniture in the future bedroom of her son, as he might injure himself during a seizure or convulsion. She commented on the stairs, in that her son was slow in going up and down stairs. Mrs. Smith did not comment on the potential danger of the stairs. The furniture was later moved as suggested by Mrs. Smith.

6. Finding: While Winnserv's co-manager on duty at the time of Mr. Smith's death had received C.P.R. and first training, not all staff were similarly trained.

Actions: Residential care operators will review first aid training of all residential staff and initiate required training. Manitoba Community Services will require first aid training for all community residence staff, and ensure such training is available. Over the longer term, the department will develop standardized job descriptions and minimum qualifications for residential managers and support staff.

Background: The co-manager on duty at 146 Wordsworth Way on December 19, 1987 took a CPR course about five years ago but never completed the examination. She has a valid St. John's Ambulance Safety Orientated First Aid Certificate.

The male hygienist who attended at 146 Wordsworth Way on December 19, 1987 believes that his St. John's Ambulance First Aid Certificate has expired. He has never received CPR training, although he understands that he is slated for a course in the near future.

The support staff worker who was on duty at 146 Wordsworth Way on December 19, 1987 completed a St. John's Ambulance Basic First Aid course approximately one year ago. She has not taken the CPR course as of yet.

7. Finding: While Winnserv's emergency notification procedures were unclear, staff acted appropriately in contacting emergency services immediately upon discovering Mr. Smith was unconscious.

Action: Manitoba Community Services will ask all community residence operators to review their emergency procedures to ensure that staff contact ambulance and police immediately when necessary.

Background: The Winnserv Residential Guidelines and Procedures noted that under Emergency Procedures, "the residential staff should always attempt to reach a Winnserv representative through the counsellor pager before calling the police or ambulance". In addition, the listing of emergency services in chronological order has the counsellor pager number preceeding that of ambulance, fire emergency at 911. Winnserv says they had given verbal instructions to staff to call 911 in the case of a "life threatening emergency".

A description of the type of seizure (Grand Mal, Petit Mal and Focal or psychomotor) is also provided. The fact that in Grand Mal and Petit Mal seizures a loss of consciousness occurs is noted. There were certain first aid procedures to be followed when dealing with seizures.

As noted previously, there were three staff members at 146 Wordsworth Way when the co-manager checked Russell Smith and discovered him with his face under the water. She called for assistance and the support staff worker and the male hygienist responded. The male hygienist assisted the co-manager while the support staff worker telephoned for emergency assistance by calling 911. It appears that emergency assistance was summoned by the staff support worker through 911, simultaneously with the co-manager and male hygienist attempting resuscitation.

8. Finding Staff turnover at this Winnserv residence had been high. In September 1987, Winnserv changed to a system of co-managers and itinerant staff. While this system reduced staff turnover, it may have contributed to communications problems at shift change, despite the use of a daily log.

Action: Winnserv will review staff utilization and consider how to reduce the number of different staff in this individual residence. Manitoba Community Services will conduct an organizational and staffing review with Winnserv. Over the longer term the department will, with residential care operators, study the issue of staff turnover to determine corrective action.

Background: When the home at 146 Wordsworth Way initially commenced operations it was managed by a live-in residential manager and support staff. With six residents this was found to require too much supervision for one residential manager and a system of two residential managers was adopted. There are support staff who assist the residential managers. There are also Winnserv staff who attend from time to time to assist with specific duties. These are a residential counsellor, behavior counsellor, a psychiatric nurse, a male hygienist and the program coordinator.

During the period from March 4 to December 13, 1987 there were 31 staff persons who had worked at 146 Wordsworth Way. Of the 31 staff, six were residential managers, including the two who are the present co-managers.

The first residential manager was employed from March to July, 1987. The second manager was a former support staff employee who assumed the position on a temporary basis for the summer months only. In August, the third manager commenced and she worked for one month and resigned. At this time, a manager from another Winnserv residence was brought in to train the future co-managers. The fifth and first co-manager commenced employment in September 1987 and the sixth and second co-manager commenced in November 1987. Two male hygienists and support staff have since commenced and terminated. The present male hygienist visits as a floater through a number of Winnserv residences.

There were and are four counsellors who visit this residence and other Winnserv residences. The psychiatric nurse visits frequently and presents lectures. There were two facilitators in training and one has completed and left. At the present time there are two support staff.

Of the remainder, some were employed as support staff at other Winnserv homes, some were and are staff who float from one Winnserv residence to another and some are relief staff who are available and are called in during times of staff shortages. During the summer months there was a high number of staff turnovers.

ANALYSIS OF ADDITIONAL PARENTAL CONCERNS

1. Mr. & Mrs. Smith expressed concern that Russell Smith travelled in a taxi without supervision from 146 Wordsworth Way to the outside day program. This was shortly after he commenced attending the outside day program and prior to Winnserv transporting Russell Smith in a van. Their concern with the taxi was that the taxi driver could have dropped him at the day program with no one to meet and supervise him. Mr. Smith pointed out that a young man who also attended the day program was recently struck by an automobile while crossing Portage Avenue and was seriously injured. Although Mr. Smith believed that his son Russell was always supervised when crossing Portage Avenue to the service station and coffee shop, he expressed concern that the other mentally handicapped person from the day program had been injured.

The matter of transporting Russell Smith from 146 Wordsworth Way to the outside day program by taxi was arranged between the day program and Community Services. The staff at 146 Wordsworth Way were responsible to see that Russell Smith got into the taxi safely when he left the residence and that he was met when the taxi returned him to the residence. The community services worker advised that when Russell Smith and another resident were to commence attending at the outside day program transportation by taxi was provided. Other transportation companies were not found to be satisfactory.

The taxi company was utilized from June 3 to June 30 and during the first week a worker from the home accompanied the residents. The taxi company attempted to have the same driver for each trip. The residents were to be placed in the taxi and were to be met by staff upon reaching their destination. The transportation by taxi was satisfactory and there were no incidents reported.

2. Mr. & Mrs. Smith were concerned that their son had lost from 10 - 20 lbs. in the months (March to December) that he was at Winnserv. Although they felt that there was probably enough for him to eat, he would not ask for more if he was hungry, but would eat all that was placed on his plate. They learned that lunch consisted of clear soup and juice one particular day. Mr. Smith recalled one Saturday lunch when a sandwich was served and he felt that this was satisfactory. Mr. Smith felt that staff would not know how much food a young man could eat. He was also concerned that other residents had also lost weight.

Russell Smith's weight chart covering the period from April to November 1987 was reviewed. His weight fluctuated from a high of 122 lbs. to a low of 114 lbs. There did not appear to be any weight taken in March 1987 or when he arrived at 146 Wordsworth Way. The MDC Discharge Summary, also failed to record his weight. A Menu Score Sheet dated November 6, 1987 recorded a scoring of 20 out of a possible 20 points and had been compiled by Residential Care Licensing. A review of the Residential Log Book indicated numerous comments concerning another resident and about whether or not he ate his meal, the quantity consumed, etc. There was a lack of specific eating information about the other residents,

including Russell Smith. This indicates that the staff were aware about possible eating difficulties with the residents. Russell Smith was described as a good eater by Winnserv staff. His weight loss, which varied between 5 and 8 lbs., they said resulted because Russell Smith being far more physically active at 146 Wordsworth Way than when he was at MDC.

3. Mr. Smith expressed concern that his son had been placed with other residents who had lesser developed skills, including communication. The day program operators apparently recognized this situation and pointed it out to the parents. The initial placement in the Wordsworth Way home was close to the parental home in the St. James area, however, the parents were hopeful that other homes were opening and would become available. Mr. Smith recommended that residents with certain developed skills should be together and learn from one another. The Winnserv staff had discussed this same situation among themselves, as they also felt that Russell Smith should have been placed with persons of comparable skill development. They also considered his behavioral problems and these, together with a lack of suitable space precluded his move.
4. Mrs. Smith alleged that Winnserv staff had, in August or September, 1987, continued to administer 60 mg dosages of phenobarbital to Russell Smith after the neurologist had reduced the dosage to 30 mg. Winnserv's medication documents, covering the period March to December 1987, were reviewed.

On August 26, the neurologist ordered a reduction in dosage from 60 mg to 30 mg. Russell Smith was at his parental home from August 27 to September 7. Staff recall that when Mrs. Smith picked up her son on August 27, the reduction in dosage was explained. To administer her son's medication for the duration of the home visit, she was given bubble packs. As the dosage reduction had just been ordered the previous day, and bubble packs supplies are refilled monthly, she was given bubble packs containing 60 mg. dosages. She was advised she could break the 60 mg. tablets in half, and administer half a tablet.

When Mrs. Smith returned her son to the residence, a staff explained to her that the 30 mg. bubble packs were on order, and that it would take a few days for the order to arrive. A staff member recalls telling Mrs. Smith that, until the 30 mg. dosages arrived, staff would continue to break 60 mg. tablets in half and administer one half of a tablet.

The nurse told the investigator the 60 mg. bubble packs were to be returned to the drug company once the 30 mg. bubble packs had arrived. The nurse said that pending receipt of the 30 mg. bubble packs, she had removed the 60 mg. bubble packs from the residence, removed the 60 mg. tablets, and refilled the bubble packs with half-tablets (30 mg. dosages).

While Mrs. Smith held the opinion that her son was receiving 60 mg. dosages of phenobarbital after 30 mg. dosages had been ordered by the neurologist, the investigation found no indication that this was the case.

5. There was a suggestion by Mr. Smith that there was a "boyfriend" at 146 Wordsworth Way on December 19, 1987. Enquiries did not support this allegation.

GLOSSARY OF TERMS

Bubble Pack

- A system of packaging an individual's prescribed medication by individual doses. This system minimizes the possibility of medication errors, as supervisory staff "pop out" each dosage, rather than dispense medication from one or more bottles.

CPR - Cardio-Pulmonary Resuscitation

Defibrillation

- Restoration of the normal rhythm of the heart muscle from an abnormal state of fine, rapid and non-productive contraction.

Drop Seizure

- One form of epileptic seizure characterized by sudden and unexpected loss of muscle control. The individual, if in a standing position, will drop to the floor.

Epilepsy

- A chronic disorder of the Central Nervous System which is manifested in sudden episodes of brain dysfunction commonly known as convulsions or seizures. Usually the seizure includes some alteration of consciousness, ranging from total unconsciousness to momentary "lapses" of attention.

There are several types of seizures, the most commonly known being the grand mal which is characterized by loss of consciousness and visible spasm and jerking of all muscles.

Face Sheet

- First page on a client record or file. This page contains basic identifying information (name, birthdate, etc.) as well as necessary individualized data. (medical diagnoses, medication, medicare number, etc.).

Level 5 Care

- The degree of care and supervision required by an individual provided with residential services is "rated" on a 5 level system. Components taken into consideration include degree of independence/dependence in activities of daily living (e.g. self care), physical abilities (e.g. mobility), ability to use generic resources and special needs (e.g. medical conditions).

An individual assessed at Level 5 Care requires intensive care and supervision due to high needs in one or more of the above factors.

MDC - Manitoba Developmental Centre,
Portage la Prairie, Manitoba

Menu Score Sheet

- An assessment sheet used by the Office of Residential Care to determine if a menu meets the standards of the Canada Food Guide.

Phenobarbital

- A commonly used medication in treatment of convulsive disorders (epilepsy).

Phenytoin

- An anti-convulsant medication used in the treatment of grand-mal epilepsy.